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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

JANA PIERCE et al.,

Plaintiffs and Appellants,

v.

LANA THI GRAY et al.,

Defendants and Respondents.

G055432

(Super. Ct. No. 30-2015-00783934)

O P I N I O N

Appeal from the judgment and postjudgment order of the Superior Court of Orange County, David R. Chaffee, Judge. Reversed and remanded.

Kyle Scott Law and Kyle J. Scott; The Ehrlich Law Firm and Jeffrey I. Ehrlich for Plaintiffs and Appellants.

Michael Maguire & Associates, Paul Kevin Wood, Jennifer Leeper, Kathryn Saldana for Defendants and Respondents.

Jana Pierce (Pierce) and Christopher Pierce (Christopher)¹ sued Lana Thi Gray (Gray) and Scott Gray for personal injuries Pierce purportedly sustained when Gray rear-ended her vehicle in a low-speed crash. A jury awarded Pierce \$2,000 in past medical expenses, \$8,000 in non-economic damages, and found against Christopher on his loss of consortium claim. On appeal, Pierce contends the trial court erred by limiting her recovery for medical expenses obtained on a lien to amounts Medicare would have paid for her care. She further asserts the court abused its discretion by prohibiting her treating physician from testifying as to the reasonable cost of the medical care she received and preventing her from presenting adequate damages evidence. Finally, Christopher claims the court erred by denying his motion for judgment notwithstanding the verdict (JNOV) and argues he should be granted a new trial on his loss of consortium claim. Because we determine the trial court committed prejudicial error by excluding almost all evidence of Pierce's damages, we lack confidence in the judgment. We reverse the judgment and postjudgment order denying Christopher's motion for JNOV. The matter is remanded for a new trial on the amount of Pierce's damages and Christopher's loss of consortium claim.

FACTS

I. Pierce's Underlying Medical Conditions

Pierce suffered neck problems prior to the collision at issue. She first experienced neck pain beginning in the early 1990s as a result of her work as a credit administrator, and ultimately had a two-level fusion at levels C-5/6 and C-6/7. Pierce continued to experience some neck pain, radiating to her arms and hands. She underwent a second cervical fusion surgery in 2003, at level C-4/5. By 2012, Pierce continued to experience constant, low-grade neck pain.

¹ We refer to Christopher Pierce by his first name for the sake of clarity and intend no disrespect.

As a result of her injuries, Pierce was awarded permanent workers' compensation disability and "lifetime medical" for claims related to her neck, arms, and hands. Because Pierce was disabled as a result of her prior medical problems, she was eligible for Medicare.² At the time of the accident, Dr. Standiford Helm was treating Pierce for her disability, which included pain medication and epidural injections.

II. The Collision and Pierce's Post-Collision Medical Treatment

In September 2014, Gray's Acura MDX struck Pierce's Toyota Prius from behind. Prior to the collision, Pierce and Gray were stopped for a red light. When the light turned green, Pierce was looking left towards oncoming traffic to see if she could make a right-hand turn. Also when the light turned green, Gray took her foot off the brake and was moving forward at a slow speed. Gray rear-ended Pierce while her head was still turned and Pierce immediately felt pain in her neck. There was no visible damage to Gray's vehicle. Pierce testified there was damage to the rear bumper of her car.

The day after the accident, Pierce was treated at Hoag Urgent Care. She complained of pain in her neck, shoulders, arms, and hands. She was prescribed pain medication.

Pierce then visited Dr. Helm, the physician for her pre-existing injuries. She told Dr. Helm about the accident and "wanted to keep the two separate" in terms of her continuing treatment versus treatment related to the accident. Eight days

² Three months after the accident, Pierce received a letter from the Centers for Medicare and Medicaid Services (CMS), confirming her Medicare eligibility. CMS informed her that under Medicare's Secondary Payer Laws, 42 U.S.C. 1395y (b) (2) and 1862 (b)(2)(A)(ii), "Medicare is precluded from paying for a beneficiary's medical expenses when payment 'has been made or can reasonably be expected to be made . . . under a Workers' Compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance.'" The letter further stated that "Medicare may pay for a beneficiary's covered medical expenses conditioned on reimbursement to Medicare from proceeds received pursuant to a third party liability settlement, award, judgment or recovery."

post-accident, Pierce saw Dr. Gerald Alexander, an orthopedic spine specialist. He ordered an MRI and referred her for physical therapy. The physical therapy helped for a short time, but the pain returned, so Pierce returned to Dr. Alexander and started to see a pain-management doctor, Dr. Carl Hess. Dr. Hess gave her epidural injections, which provided short-term relief.

In May 2016, Dr. Alexander performed Pierce's third cervical fusion surgery at levels C-3/4. The surgery resulted in a loss of movement to her neck and weakness in her hand. Pierce continued to have discomfort and pain in her neck and lower back and could not work long hours.

III. Procedural Summary

Pierce and Christopher filed suit against Gray and her husband in April 2015, alleging negligence, negligence per se, and loss of consortium. Prior to trial, the trial court granted Gray's motion in limine to "preclude purported evidence of medical costs in an amount greater than what [Pierce's] medical providers will accept as payment in full." Gray filed a trial brief arguing Pierce's recovery of medical expenses should be limited to what Medicare would have paid had she treated through Medicare. Gray further argued Pierce should be precluded from introducing evidence of unpaid medical bills and that Pierce's treating physician and medical expert, Dr. Alexander, was attempting to testify as to the full billed amounts of treatment.

Pierce moved to exclude any reference to Medicare during the trial. Pierce also argued she was entitled to present the full billed amount of her lien-based medical treatment despite the fact Dr. Alexander accepted Medicare and she had such coverage.

The trial court determined "if the physician is enrolled in Medicare and [medical] bills are not submitted [to Medicare], the plaintiff's claim has to be limited to the Medicare amount." Upon making this ruling, the trial court conducted an Evidence Code section 402 hearing (402 hearing) of Dr. Alexander. The court, and then counsel, questioned Dr. Alexander about his billing practices. Dr. Alexander testified he accepts

Medicare patients, but was not aware Pierce was Medicare eligible. Dr. Alexander explained his knowledge of medical pricing comes from many sources, including what he charges his own patients. He further stated he has been board certified in orthopedic surgery for 16 years. When asked about his experience with regard to medical pricing, Dr. Alexander replied: “My experience includes information from multiple sources that would include my own patients who have undergone surgery, where I’ve seen their charges from facilities, I’ve seen the payments to those facilities. I’ve seen payments to other physicians or health care providers for my patients, including therapists, chiropractors, et cetera. I’ve also reviewed many cases that weren’t my patients and have reviewed those types of things. [¶] I have even been a partial owner at one time of an outpatient surgery center and was involved in pricing for various procedures, including spine surgery, injections and either -- and even procedures in other fields of medicine such as ENT, GI, et cetera.” Pierce’s counsel then asked Dr. Alexander whether he had experience in evaluating medical bills for the types of medical providers who treated Pierce on a lien, including pain management, physical therapy, and surgery centers. Dr. Alexander responded, “yes” to each.

Dr. Alexander testified that if he had treated Pierce on a Medicare basis it may have “altered” her treatment in that there are “limitations of the tests you can order, of therapy you can order, limitations of the types of procedures that can be done.” However, he acknowledged that these limitations apply to “all insurance carriers, including government ones like Medicare.” One specific example of how Pierce’s treatment would have been different under Medicare is that her surgery would have to take place at a hospital as opposed to a surgery center, because no surgery centers where he worked accepted Medicare for this type of procedure.

Dr. Alexander further explained during the 402 hearing if the surgery had been performed at a surgery center pursuant to Medicare coverage, the “ballpark range” of the amount paid would be approximately \$25,000. As to this specific surgery,

however, Dr. Alexander could not testify as to what Medicare would have paid him or the surgery center. However, based upon a prior surgery at Placentia-Linda Hospital, which Dr. Alexander performed and for which Medicare was billed, Dr. Alexander estimated he was paid \$5,000 to \$6,000. He also stated that even though he has accepted Medicare patients in the past and currently has privileges at Placentia-Linda Hospital, he never attempted to treat Pierce as a Medicare patient because he was unaware she was Medicare eligible.

After the trial court indicated its intent to limit Dr. Alexander's testimony to areas where a foundation could be laid, Pierce asked to question the doctor for an opinion as to the "reasonable and necessary" amount of Medicare reimbursement for Pierce's surgery. The court explained that Pierce could ask the doctor "if his charges were reasonable and necessary." However, the court determined Dr. Alexander lacked knowledge as to Medicare reimbursement rates and the court precluded Pierce from asking Dr. Alexander for his estimates of what Medicare would have paid, "unless there is some evidence with respect to the Medicare amount." Pierce then asked to attempt to lay a foundation for the amounts of Medicare reimbursement and the court agreed. However, no specific evidence as to Medicare rates was provided.

The trial court revisited the damages issue, at which time further legal argument was held as to what counsel could or could not ask Dr. Alexander. The court reaffirmed its ruling. Counsel for Pierce requested to question Pierce about Medicare coverage, specifically, regarding the two Medicare bills she received and owed, and the court agreed. Counsel also asked if he was able to ask Pierce if she signed an agreement regarding treatment on a lien. The court replied affirmatively, "I'm not going to preclude her from saying that she signed an agreement to repay . . . to these medical providers. You get to ask her about Medicare coverage," and appellant's counsel replied, "Okay. Perfect."

In light of the trial court's rulings, the only evidence of the cost of

Pierce's medical care presented to the jury was two items paid by Medicare, for the urgent care visit and one doctor visit. Collectively, between what Medicare paid for the two visits and what Pierce paid out-of-pocket, the costs totaled only \$407.24.

IV. Pierce's Trial Testimony

Pierce testified her current neck pain is "stronger" than before the collision, despite her most recent cervical fusion surgery. She admitted she is still able to run errands, including driving several hours at a time. Pierce also testified just before the accident, it was "highly possible" she was suffering increased pain in both thumbs, tingling in her hands, and headaches, and, as noted above, she already had an epidural injection scheduled before the accident occurred.

As to her medical expenses, Pierce testified she entered into lien agreements with the various providers who treated her, and that she still owes the amounts stated in the lien agreements. She was not permitted to testify as to the lien amounts. On cross-examination, defense counsel was allowed to ask her about the two items of care that Medicare paid, and whether what Medicare paid was lower than the amount charged.

V. Expert Trial Testimony

Dr. Alexander first treated Pierce in September 2014. He testified her degenerative changes and prior surgeries made her more susceptible to injury. In October 2014, Dr. Alexander stated MRI results indicated a disk protrusion at levels C3-C4. He further stated that while there was a "minor degree of degeneration or aging at that level," the likely cause of Pierce's "worsening symptoms" was the auto accident. However, he admitted that the accident did not "cause" plaintiff's complaints; rather, it merely made them worse. Dr. Alexander eventually performed a level C3-C4 cervical fusion upon Pierce at a surgery center. Dr. Alexander also opined all of the medical treatment provided to Pierce, whether by himself, Dr. Hess (epidural injections), Dr. Pearce (anesthesiologist), and Hoag (urgent care), etc., was "reasonable and necessary" and was

“due to” the accident with Gray. He admitted that the billing from the surgery center was not entirely “reasonable” because “it was somewhat high.” Dr. Alexander explained to the jury that he had experience in medical billing and once owned an interest in a surgery center.

Dr. Nitin Bhatia testified as a medical expert for Gray. Dr. Bhatia is an orthopedic surgeon specializing in spinal surgery. After reviewing Pierce’s medical reports, Dr. Bhatia noted the pre-accident results showed mild degenerative changes to the spine at levels C3-C4 and C7-T1. He observed the MRI showed no “post-trauma findings,” but rather mild degenerative progression. The MRI findings were consistent with Dr. Bhatia’s examination of Pierce, which led him to conclude Pierce suffered a muscle strain to the neck and low back as a result of the accident, but did not suffer any structural injury. He stated she did not require surgery of any kind due to the accident. He opined the total reasonable value of the care that Pierce received as a result of the accident was \$2,000. No future care was required.

Pierce’s accident reconstruction expert, Joseph Gilbert Yates, opined Gray’s vehicle was traveling between eight and 13 miles per hour at the time of impact. Pierce’s biomechanical and accident reconstruction expert, Vijay Gupta, also opined there was a biomechanical mechanism to cause Pierce’s cervical disk injuries at levels C3-C4 and C7-T1.

Gray’s biomechanical and accident reconstruction expert, Dr. Peter Burkhard, estimated Gray was traveling two to four miles per hour at the time of impact. He equated the amount of force to that of hitting a curb while in a parking lot. He opined the accident involved lesser force than being bumped in an amusement park bumper car. Dr. Burkhard questioned Yate’s speed of impact analysis, stating impact in that range would have caused more damage to the vehicles.

IV. Jury's Determination and Posttrial Matters

The jury found that Gray's negligence was a substantial factor in causing harm to Pierce, that her total past economic damages were \$2,000; her future economic damages were zero; her past non-economic damages were \$8,000; and her future non-economic damages were zero. The jury found that Gray's negligence was not a substantial factor in causing any harm to Christopher, and so made no further findings concerning his loss of consortium claims.

Christopher filed a motion for judgment notwithstanding the verdict (motion for JNOV) on the loss of consortium claim, and he and Pierce moved for a new trial. After the trial court heard the motions, it issued a tentative ruling which became the final ruling. The trial court denied Christopher's motion for JNOV, noting that while Christopher's position was that CACI 3920 provides for "strict liability," in fact "loss of consortium is a separate claim with its own essential elements."

As to the motion for new trial, the trial court noted Pierce conceded that not only was she a Medicare beneficiary, but that Dr. Alexander knew very little about Medicare billing amounts, meaning Pierce had no evidence as to the "reasonable value," as opposed to the irrelevant "billed" amount, for Mrs. Pierce's medical treatment. The court also noted that the jury's award implied Pierce had only "minor injuries" and did not require further surgery. Pierce appealed from both the judgment and the trial court's order denying Christopher's motion for JNOV.

DISCUSSION

Pierce contends the trial court erred by precluding evidence of both the amount of the treatment lien and Dr. Alexander's testimony as to the amount of reasonable charges for Pierce's medical treatment. Christopher contends this evidentiary error prejudiced his loss of consortium claim, requiring reversal. Pierce requests we take judicial notice of an insurance-related handbook and Web pages. Because we determine the court's evidentiary rulings concerning the amount of Pierce's damages were

erroneous and prejudicial, we reverse the judgment and postjudgment order denying Christopher's motion for JNOV. We deny Pierce's request for judicial notice.

Generally, a tort plaintiff should not be placed in a better position than he or she would have had if the wrong had not been done. (*Valdez v. Taylor Automobile Co.* (1954) 129 Cal.App.2d 810, 821-822.) A plaintiff may not typically recover more than the actual amounts paid for past medical services, even though the amounts billed for those services were greater. (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 555-556.) "Thus the general rule under the Restatement, as well as California law, is that a personal injury plaintiff may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services. (*Id.* at p. 556.)

"An injured plaintiff with health insurance may not recover economic damages that exceed the amount paid by the insurer for the medical services provided. [Citation.] The amount of the 'full bill' for past medical services is not relevant to prove past or future medical expenses and/or noneconomic damages. [Citation.] In contrast, the amount or measure of economic damages for an uninsured plaintiff typically turns on the reasonable value of the services rendered or expected to be rendered. [Citation.] Thus, an uninsured plaintiff may introduce evidence of the amounts billed for medical services to prove the services' reasonable value. [Citation.]" (*Pebley v. Santa Clara Organics, LLC* (2018) 22 Cal.App.5th 1266, 1268-1269 (*Pebley*).)

I. The Trial Court's Evidentiary Rulings on the Amount of Damages Constituted an Abuse of Discretion

Because the trial court precluded Pierce from introducing evidence of the cost of her care and directed the jury that it could only award damages based on the cost of the minimal Medicare charges, the court's rulings foreclosed the jury from making anything but a de minimis award to Pierce for medical expenses. This was an abuse of discretion.

We review a trial court's decision to exclude expert testimony for abuse of discretion. (*People v. Bolin* (1998) 18 Cal.4th 297, 321-322.) "[W]here evidence is improperly excluded, the error is not reversible unless "it is reasonably probable a result more favorable to the appellant would have been reached absent the error. [Citations.]" [Citation.]" (*Tudor Ranches, Inc. v. State Comp. Ins. Fund* (1998) 65 Cal.App.4th 1422, 1431-1432.) "In order to testify as an expert . . . a person must have enough knowledge, learning and skill with the relevant subject to speak with authority, and he or she must be familiar with the standard of care to which the defendant was held. [Citations.] An expert may base his or her opinion on any matter reasonably relied upon by experts in forming opinions about the particular subject matter in question, except when the law precludes consideration of a particular matter. [Citation.] If the expert has disclosed sufficient knowledge of the subject to entitle his or her opinion to go to the jury, the court abuses its discretion by excluding his or her testimony. [Citation.]" (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 467-468.)

Prior to limiting Dr. Alexander's testimony about damages, the trial court determined "if the physician is enrolled in Medicare and [medical] bills are not submitted [to Medicare], the plaintiff's claim has to be limited to the Medicare amount." The court then conducted the 402 hearing of Dr. Alexander and excluded his testimony as to the amounts of the medical lien Pierce was liable for post-surgery and the reasonable cost of the charges incurred by Pierce for her treatment. This occurred despite Dr. Alexander's testimony as to his experience with medical pricing, billings, and payments in a variety of situations. The court concluded Dr. Alexander could not lay a foundation as to the specific amount Medicare would have paid for Pierce's treatment.

We determine the trial court abused its discretion in prohibiting Dr. Alexander's testimony on any amount of medical damages incurred by Pierce. Dr. Alexander was well-qualified to testify as to medical billing and as Pierce's treating surgeon, was a proper witness to testify as to the reasonable cost of care for her treatment.

His underlying qualifications were not questioned, but merely his ability to lay a foundation as to the amount Medicare would hypothetically have paid in this case. However, Pierce did not inform Dr. Alexander of her Medicare eligibility, he did not treat Pierce as a Medicare patient, and Dr. Alexander had no basis to testify as to the precise amounts Medicare would have theoretically billed Pierce. The record is silent as to why Pierce failed to disclose her Medicare eligibility and we will not speculate as to her underlying intent.

The trial court prevented Dr. Alexander from testifying as to the amount of Pierce's medical liens or the reasonable costs for her care. The court explained that while Dr. Alexander was qualified to testify as to the reasonableness of the services, the reasonable value required something else. The court went on to explain the only means for a plaintiff to prove the reasonable amount of medical costs was "to have a survey conducted for a cross section of the reasonable charges rendered by a cross section of the local community." In the court's view, "a single doctor" cannot satisfactorily testify about what costs are reasonable based on his or her understanding of the market for medical services. We decline to adopt this rigid view. Refusing to admit the testimony of a qualified physician familiar with medical billing as to the reasonable value of a surgery he performed himself was an abuse of discretion. Indeed, Gray's medical expert opined the total reasonable value of the care that Pierce received as a result of the accident was \$2,000. We note that any concerns about Dr. Alexander's testimony, such as any purported financial incentive to overstate the reasonable value of his services as a result of his lien, pertain to weight, not admissibility, and such issues could be cross-examined. (*Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, 1340 fn 11 (*Bermudez*).)

As to the trial court's exclusion of evidence of the amount of the underlying lien, Pierce contends *Pebley* is analogous because plaintiffs who choose not to use their insurance should be treated at trial as uninsured for the purpose of determining economic damages. We agree.

Pebley involved an insured plaintiff who chose to treat with doctors outside his insurance plan. (*Pebley, supra*, 22 Cal.App.5th at p. 1269.) *Pebley* determined “such a plaintiff shall be considered uninsured, as opposed to insured, for the purpose of determining economic damages.” (*Ibid.*) This allowed the plaintiff to introduce his unpaid medical bills and his medical experts confirmed the bills represented the reasonable costs for his medical services. (*Ibid.*) Defendants sought to exclude evidence of unpaid bills from plaintiff’s doctors, which would have required plaintiff to introduce independent evidence of market rate values for his care. (*Id.* at p. 1272.) The defense also sought to prevent Dr. Alexander³ from offering opinions on the ““reasonableness”” of medical expenses based on unpaid billed amounts. (*Ibid.*) The trial court denied both motions. (*Ibid.*) “The trial court stated it was extending the ruling in *Bermudez*, which involved an uninsured plaintiff, to cover the facts of this case. As a result, the full lien amounts that were billed were admissible.” (*Ibid.*) The Court of Appeal determined the “trial court properly allowed *Pebley*, as a plaintiff who is treating outside his insurance plan, to introduce evidence of his medical bills. *Pebley*’s medical experts confirmed these bills represent the reasonable and customary costs for the services in the Southern California community.” (*Id.* at p. 1269.)

An injured plaintiff “is entitled to recover the lesser of (1) the amount incurred or paid for medical services, and (2) the reasonable value of the services rendered. [Citations.] The fact that [a plaintiff] chose to pay for [medical] services out of pocket, rather than use [] insurance, is irrelevant so long as these requirements are met. . . . A tortfeasor cannot force a plaintiff to use his or her insurance to obtain medical treatment for injuries caused by the tortfeasor. That choice belongs to the plaintiff. If the plaintiff elects to be treated through an insurance carrier, the plaintiff’s recovery typically will be limited to the amounts paid by the carrier for the services provided. [Citation.]

³

The *Pebley* case involved the same Dr. Alexander.

But where, as here, the plaintiff chooses to be treated outside the available insurance plan, the plaintiff is in the same position as an uninsured plaintiff and should be classified as such under the law.” (*Pebley, supra*, 22 Cal.App.5th at pp. 1276-1277.)

The *Pebley* court recognized that “[t]here are many reasons why an injured plaintiff may elect to treat outside his or her insurance plan.” (*Pebley, supra*, 22 Cal.App.5th at p. 1277.) These include the fact that plaintiffs often choose their insurance plan before they are injured, and therefore without regard to whether the plan would provide the best care for the injuries they suffered; that an injured plaintiff may prefer to be treated by a physician who specializes in the treatment required, who may not accept the plaintiff’s insurance; and that insurance-paid providers may be less willing to participate in the litigation process than lien providers. (*Id.*) The *Pebley* court also agreed that, because plaintiffs must live with the physical consequences of their treatment decisions, there is little chance that plaintiffs will make treatment choices designed solely to increase their medical expenses in an attempt to inflate their damage awards. (*Id.*)

Pierce, like the *Pebley* plaintiff, had a form of insurance but chose to pay for her medical services out-of-pocket. (*Pebley, supra*, 22 Cal.App.5th at p. 1269.) The record is silent as to Pierce’s specific reasons for seeking treatment on a medical lien. We note, however, that while Dr. Alexander testified he accepts Medicare patients, he also identified specific differences with the care a Medicare patient would receive versus the treatment given to Pierce. Namely, Pierce’s surgery would have occurred in a hospital, not a surgery center.

Ultimately, the facts showed Pierce, not Medicare, was liable for her medical bills. “It would be inequitable to classify [plaintiff] as insured when [plaintiff], and not an insurance carrier, is responsible for the bills. Indeed, precluding [plaintiff] from recovering the reasonable value of the services for which he [or she] is liable would result in both undercompensation for [plaintiff] and a windfall for defendants. [Citation.]” (*Pebley, supra*, 22 Cal.App.5th at pp. 1277-1278.) The trial court abused its

discretion in excluding evidence of the full lien amount and Dr. Alexander's expert testimony as to the reasonable value of the care he rendered. This exclusion resulted in Pierce being able to claim a mere \$407.24 in damages for a complicated spinal surgery. If evidence of Pierce's damages had been admitted at trial, it would not have precluded Gray's testimony and evidence contradicting Pierce's damages as unreasonable. We reverse the judgment because it was reasonably probable a result more favorable to Pierce would have been reached absent this error.⁴ We remand for a new trial on damages.

II. Loss of Consortium Claim

Pierce argues if she is entitled to a new trial, then Christopher also is entitled to a new trial. Christopher similarly contends the court erred by denying his motion for JNOV on the loss of consortium claim. We agree.

As discussed above, we find prejudicial error occurred with the trial court's evidentiary rulings. This error tainted the proceedings and gave an incomplete picture of the damages claimed by Pierce. Ultimately, the court's rulings prevented Pierce from presenting any evidence of the amount of the medical bills she incurred or testimony that some or all of that amount was reasonable. Christopher's claim for loss of consortium appeared to be based on an injury that cost, at most, only \$2,000 to treat. Had Pierce been able to present her damages evidence, there is a reasonable probability the jury would have found for Christopher on the loss of consortium claim. (*Saxena v. Goffney* (2008) 159 Cal.App.4th 316, 334-335). Because we lack confidence in the judgment, we determine the loss of consortium claim must also be reversed and remanded for a new trial.

⁴

We express no opinion as to the proper amount of damages to be awarded on remand, as that is the province of the jury. We note, however, "clearly, the notion is the full amount billed is not the appropriate amount, it's somewhere . . . below that. . . . So it really boils down to a . . . battle of the experts." (*Pebley, supra*, 22 Cal.App.5th at p. 1272.)

III. Pierce's Request for Judicial Notice

Appellate courts will not judicially notice evidentiary matters which cannot properly be considered for the first time upon appeal. (*Simmons v. Southern Pac. Transportation Co.* (1976) 62 Cal.App.3d 341, 366-367.) Rather, matters which are the subject of judicial notice include things such as “[r]egulations and legislative enactments issued by or under the authority. . . of any public entity,” or “[r]ecords of (1) any court of this state or (2) any court of record of the United States or of any state of the United States.” (Evid. Code § 452, subds. (b), (d).)

Pierce filed a request for judicial notice seeking to introduce a Medicare handbook and several insurance-related Web site pages. None of the evidence sought to be judicially noticed at the appellate stage was introduced at the trial court. The request for judicial notice fails to explain how the handbook and Web site pages are equivalent to “records of . . . any court” or “regulations and legislative enactments,” or why we should accept this evidence in the first instance.

Furthermore, the evidence Pierce requests judicial notice of is irrelevant to the issues on appeal. Pierce purports to offer the information as evidence of “the nature of public and private insurance available in California.” Indeed, the “nature” of public and private insurance is set forth in numerous statutes and regulations. Pierce’s request for judicial notice is denied.

DISPOSITION

Pierce's request for judicial notice is denied. The judgment and postjudgment order denying Christopher's motion for JNOV are reversed. The matter is remanded to the trial court for a new trial on the issues of damages and loss of consortium. Pierce shall receive her costs on appeal.

O'LEARY, P. J.

WE CONCUR:

MOORE, J.

GOETHALS, J.